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Case Report

A case of granuloma faciale

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Abstract A 60-year-old housewife reported with a raised red lesion on the left cheek since the last four months. Local examination revealed a well-defined erythematous indurated plaque 3×3 cm^2 with geographical borders on the left cheek close to the angle of mouth. Routine investigations were normal. Histopathology revealed loosely scattered granulomas in the dermis with lymphocytes, plasma cells, neutrophils and eosinophils. A disease free Grenz zone was seen. A diagnosis of granuloma faciale was made and the patient was put on intralesional steroid therapy. She continues to be on regular follow up.

Key words
Granuloma faciale.

Introduction

Granuloma faciale is an idiopathic vasculitis presenting as a granulomatous plaque or nodule on the face usually.[1-4] Extrafacial involvement is known to occur. It involves middle aged males from a rural background especially. The plaques are mostly solitary, elevated, well-circumscribed up to several centimeters in diameter and may be annular at times.[3] The colour is usually reddish. Prominent follicular orifices along with surface telangiectasia are seen. In all cases there is absence of ulceration. Biopsy reveals a characteristic histopathology of eosinophilic infiltrate, loose granulomas and a free Grenz zone.[5] Treatment modalities may include intralesional steroid injections, dapsone and hydroxychloroquine although the response is rarely satisfactory.[6]

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Case report

A sixty-year-old rural housewife, non diabetic, normotensive, reported to the outpatient department of Dermatology, STD & Leprosy SMHS Hospital (associated teaching hospital of Government Medical College, Srinagar Kashmir) with the chief complaints of eruption of a raised reddish lesion on the left cheek since the last four months (**Figure 1**).The lesion started as a small firm area which progressively enlarged over the next four months to reach the present dimensions. There was no history of preceding insect bite, pain, itching, discharge or numbness over the lesions. No history of photosensitivity, flushing or summer exacerbation was elicited. Past and drug history was non contributory.

Local examination revealed a well-defined erythematous indurated plaque 3×3 cm2 with geographical borders on the left cheek close to the angle of mouth (**Figure 1**). No satellite lesions, vesiculation, exudation, telangiectasia, follicular prominence, scaling, loss of

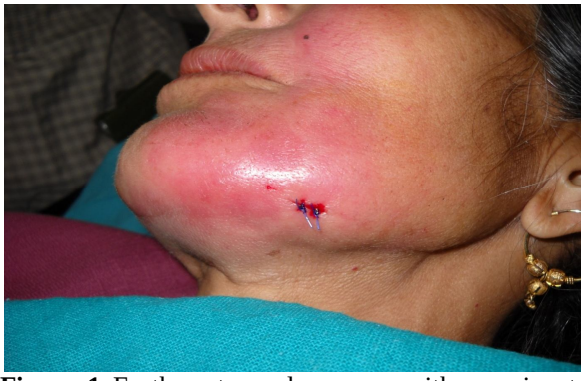

Figure 1 Erythematous plaques on with prominent follicular openings.

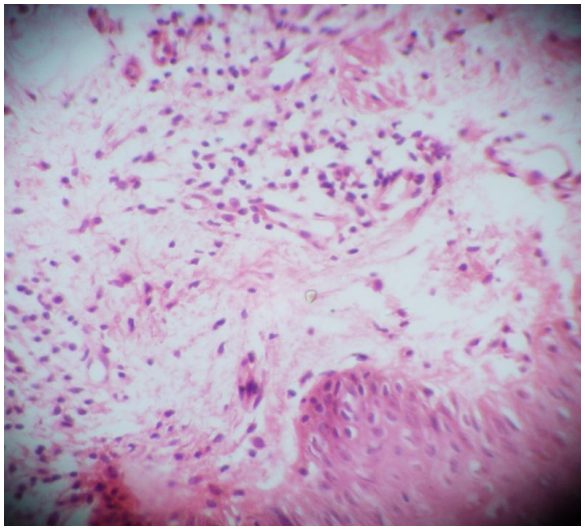

Figure 2 Loose granulomas in the upper dermis.

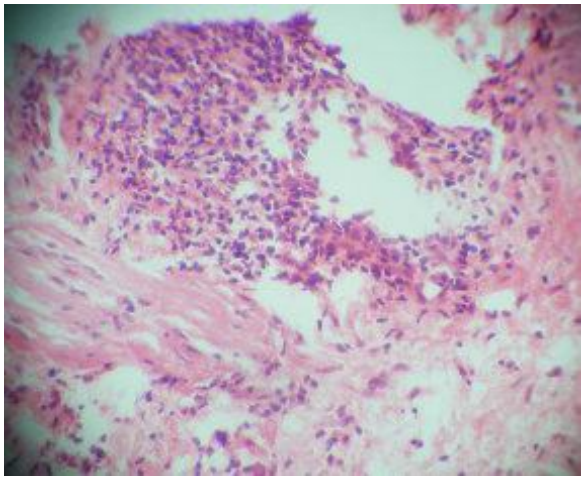

Figure 3 A polymorphous infiltrate of neutrophils, eosinophils, lymphocytes and plasma cells.

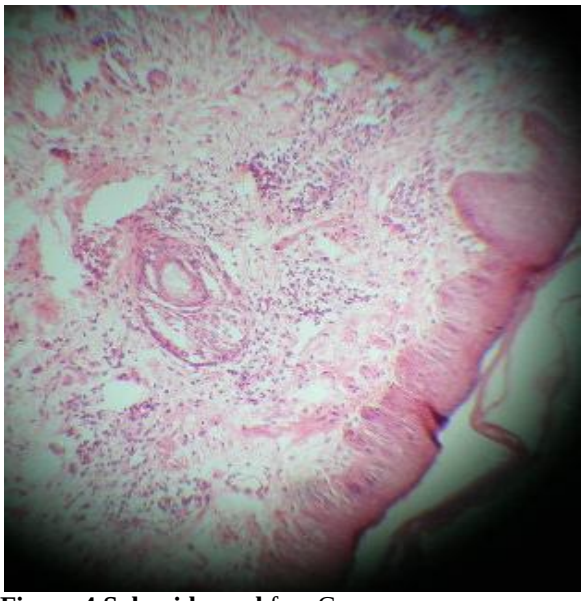

Figure 4 Subepidermal free Grenz zone.

appendages, crusting or ulceration was seen over the plaque. No signs of inflammation, regional lymphadenopathy, facial nerve palsy or fissuring of tongue were seen. Diascopy revealed blanching of the lesion. General physical and systemic examination was normal.

Routine investigations were normal. Serum calcium levels, angiotensin converting enzyme (ACE) levels and skiagram chest were normal. Histopathology (**Figures 2-4**) revealed loosely scattered granulomas in the dermis with lymphocytes and plasma cells. The predominant infiltrate was of neutrophils and eosinophils. A disease free Grenz zone was seen. Nerves and appendages were uninvolved. No vasculitis was seen. A diagnosis of granuloma faciale was made and the patient was put on intralesional steroid therapy. She continues to be on regular follow up although the response is not satisfactory.

Discussion

Granuloma faciale is an idiopathic vasculitis with a characteristic histopathology of

eosinophilic infiltrate, loose granulomas and a free Grenz zone. Evidence of vasculitis in the biopsy may be missing. Sarcoidosis was ruled out by the loose arrangement of granulomas and presence of eosinophils on histopathological examination. Normal serum calcium and ACE levels further ruled it out. Lymphocytoma cutis, granulomatous rosacea, leishmaniasis, leprosy, syphilis and follicular mucinosis were considered in the differential diagnosis. In our patient the classical clinical picture and histopathology helped us to clinch the diagnosis.

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